Sláinte Leanaí Éireann
ag Cromghlinn
Children's Health Ireland
at Crumlin

CHILD

NURSING ADMISSION ASSESSMENT: INPATIENT

Full Name: .....
Address: .....
.....
.....
Date of Birth:.....
HCR.....

DATE OF ADMISSION		**TIME**	

Consultant..... Ward:.....
Age: ..... Gender: ..... Religion: .....
Identity Bracelet(s) correct and in situ: One □ Two □ Weight .....kg Height .....cm
Body Surface Area: .....
Support Required: Yes □ No □ *Give Details:*.....

REASON FOR ADMISSION

NEXT OF KIN DETAILS

Parent / Legal Guardian 1	***Parent / Legal Guardian 2***
Name:_____ Relationship to child:_____ Home Phone No:_____ Mobile No:_____	Name:_____ Relationship to child:_____ Home Phone No: _____ Mobile No:_____
Siblings & their ages:	Significant other/s living at home:

GP	**PUBLIC HEALTH NURSE**	**PHARMACY**
Name:	Name:	Name:
Address:	Address	Address
Phone: Fax:	Phone: Fax:	Phone: Fax:

RELEVANT HEALTH HISTORY

MEDICATION ON ADMISSION:
(as per person accompanying the child. Verify the doses against the medication labels of healthcare record before prescribing)

PEWS SCORE:.....**Date:**.....**Time:**.....

Special Needs Assessment: Yes □ No □

Has commenced Menarche: Yes □ No □ NA □ Is HCG required: Yes □ No □

Information obtained from *(Print Name):*.....**Date:**..... **Time:** .....
Nursing Student *(Print Name):* .....**NMBI:** .....
Registered Nurse Name *(Print Name):* .....**NMBI:** .....

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INFECTIOUS DISEASES

Contact with Infectious Diseases in last 4 weeks: *Covid, Measles, Mumps, Rubella, Pertussis, Chickenpox, Gastroenteritis, other*
Yes □ No □ *Give details*:.....
In the last 72 hours, has the child: Vomited: Yes □ No □ Had Diarrhoea: Yes □ No □
Give details: .....
Is the child known to be colonised with resistant organisms e.g. MRSA, ESBL, VRE, CRE: Yes □ No □
Transfer from other hospital: Yes □ No □ Attended a hospital abroad or known CRE hospital: Yes □ No □
Give details: .....
Needs isolation: Yes □ No □ *Reason:* .....
Covid Swab done: Yes □ No □ Covid Precaution: Yes □ No □ Covid Result: .....

VACCINATIONS: upto date □

None □ Unknown □ *Give details:* .....

Covid 19 Vaccinated: Yes □ No □

1st dose given: Yes □ No □ Date of 1st dose:..... Type of Covid Vaccine given:.....

2nd dose given: Yes □ No □ Date of 2nd dose:..... Date of Booster:.....

Boosters aged 5yrs: Yes □ No □ BCG: Yes □ No □ HPV: Yes □ No □

BREATHING

Any history of breathing problems: Yes □ No □ Breathing Assessment as per PEWs: Yes □ No □

Respiratory support required: Yes □ No □ *Details:* BiPAP □ CPAP □ Humidified High Flow Nasal Cannula □

ALLERGIES None known □

Allergies: *(as per person accompanying the child)*
Allergic to medication: Yes □ No □ Name: _____
Reaction type: _____
Allergic to food: Yes □ No □ Name: _____
Reaction type: _____
Allergic to plasters / tape: Yes □ No □ Name: _____
Reaction type: _____
Other: _____

ALLERGIES DOCUMENTED IN HcRN: YES □ NO □

MAINTAINING A SAFE ENVIRONMENT

Orientated to ward: Yes □ Ward routine explained: Yes □ Ward Safety & Guidance explained: Yes □
Any special safety needs: .....

MAINTAINING BODY TEMPERATURE

Temperature on admission: ..... Tempa Dot: Yes □ Tympanic: Yes □

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ELIMINATION

Toilet Trained

Independent: Yes □ No □ Needs assistance: Yes □ No □ *Details:* _____

Trained By day: Yes □ No □ By night: Yes □ No □ Urinalysis: _____

Lift at night: Yes □ No □ Wears nappies Yes □ Pull ups □

Bowel Habit

Independent with toileting: Yes □ No □

*If no, please give details of assistance required*_____

Bowel Habit: *How often*: _____

Normal Stool: Yes □ No □ Constipation: Yes □ No □ Diarrhoea: Yes □ No □

Stool softeners: Yes □ No □ *Name*:_____

EATING AND DRINKING

Normal diet □ Eats and drinks independently: Yes □ No □ With assistance: Yes □ No □ Other □
*Please give details:*_____
Takes medication orally Yes □ No □ *Tablet* □ *Liquid* □ *Both* □ *Using a spoon* □ *Using a syringe* □
Any special requirements, please detail below If no, tick N/A □
Breastfeeding □ Partial □ Spoon Feeds □ Formula □ NG □ NJ □
PEG □ Mickey □ Trans Gastric Jejunal □ NPO □
Feed Type :_____ Volume:_____ No. of feeds: _____
Dietary requirements: Pureed □ Mashed □ Regular □ Other □
Special Dietary requirements…..... Fasting on admission: Yes □ No □
Last ate at: ____:____hours Last drank at:____:____hours
*If no, please give details of assistance required*_____

WASHING AND DRESSING

Independent with washing and dressing: Yes □ No □
If no, please give details of assistance required:_____
Skin condition: Normal □ Not Normal □ *Give details:* _____
Scars □ Rash □ Pressure Area □ Location: _____
Wound: Yes □ No □ Location: _____
Is Children's Wound Assessment Tool in use: Yes □ No □

Mouth and teeth checked and clean: Yes □ No □ *Details*: _____
If no, has Oral Assessment Tool 1/2/3 been commenced Yes □ 1 □ 2 □ 3 □
Hair checked: Yes □ No □ *If no, please give details of assistance required*_____
Hair Clean: Yes □ No □ *If no, give details*:_____

Peripheral or Central Venous Access devices in situ:
Please tick PVC □ CVC □ PICC □ Vascath □ Broviac / Hickman □ *Other*_____

Appropriate Care Bundles commenced: Yes □ No □

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PRESSURE ULCER ASSESSMENT TOOL *Not applicable* □

Reduced mobility / Bed rest : Yes □ Device in situ, e.g. cannula □ Incontinence inappropriate for age □

Reduced nutritional intake / Fasting more than 2 days: Yes □ No □ Sensory / Cognitive Impairment □

Altered tissue perfusion: Yes □ No □ Other □

Please specify:_____

COMMUNICATION

Vision: Normal □ Wears glasses □ Visually impaired Yes □ No □

Hearing: Normal Yes □ No □ *If no, give details*_____

Speech: Normal Yes □ No □ *If no, give details*_____

Attends Speech & Language Therapy: Yes □ No □

Language: English first Language: Yes □ No □ Language:_____

Interpreter Required: Yes □ No □

MOBILISING *(current level of mobility)*

Independent: Yes □ No □ Partial Assistance: Yes □ No □ Full assistance Yes □ No □

Crutches: Yes □ No □ Wheelchair: Yes □ No □ Other_____

PLAY AND LEARNING

Current level of education: At home □ Nursery / Creche □ Pre-School □ Primary School □ Secondary School □

Class year: _____ Can attend hospital school: Yes □ No □

If no, please comment _____

Playroom facility explained: Yes □ No □

SLEEP AND COMFORT

Sleeps in: Bed □ Cot □ Alone: Yes □ No □ with_____

Comforter: Yes □ No □ *Give details*:_____

Pain Assessment Score on admission required Yes □ No □
Pain Assessment Tool used: FLACC □ Faces □ Numeric □
Pain Assessment Score:.....

Any other information

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Registered Nurse Name *(Print Name)*:..... **NMBI**:.....